NCLR CENTER FOR HEALTH PROMOTION

NATIONAL COUNCIL OF LA RAZA

DEVELOPING EFFECTIVE HEALTH COALITIONS: THE ROLE OF HISPANIC COMMUNITY-BASED ORGANIZATIONS

THE NATIONAL COUNCIL OF LA RAZA (NCLR)

The National Council of La Raza (NCLR), the largest constituency-based national Hispanic organization, exists to improve life opportunities for the more than 22 million Americans of Hispanic descent. In addition to its Washington, D.C. headquarters, NCLR maintains field offices in Los Angeles, California; Phoenix, Arizona; McAllen, Texas; and Chicago, Illinois. NCLR has four missions: applied research, policy analysis, and advocacy on behalf of the entire Hispanic community; capacity-building assistance to support and strengthen Hispanic community-based organizations; public information activities designed to provide accurate information and positive images of Hispanics; and special innovative, catalytic, and international projects. NCLR acts as an umbrella for more than 140 affiliated Hispanic community-based organizations which together serve 36 states, Puerto Rico, and the District of Columbia, and reach more than two million Hispanics annually.

THE NATIONAL COUNCIL OF LA RAZA CENTER FOR HEALTH PROMOTION

The NCLR Center for Health Promotion provides technical assistance to NCLR affiliates and other national, regional, and local entities which share a commitment to health-related education and disease prevention in the Hispanic community. The NCLR Center for Health Promotion houses the following initiatives:

- The NCLR AIDS Center, established in 1988 through a grant from the Centers for Disease Control, carries out interrelated activities built around the concept of an interactive HIV/AIDS network: information sharing, development of guides and manuals, development of program models, training, and capacity-building technical assistance.

- The Hispanic Health Liaison Project, established in the fall of 1991 through a grant from the Office of Minority Health, is designed to provide information, assistance, and support to Hispanic community-based organizations committed to increasing Hispanic involvement in preventive health efforts, and serve as a bridge between community-based organizations and mainstream agencies, public and private. A major product of the project will be a comprehensive report on Hispanic health status designed to increase awareness and understanding of Hispanic health needs among policy makers, mainstream organizations, the media, the Hispanic community, and the general public.

- Special health initiatives such as an analysis of Hispanic health insurance coverage and seminars and conference workshops on substance abuse, HIV/AIDS, and other health issues.

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INTRODUCTION

This document is designed to assist Hispanic community-based organizations interested in developing effective long-term health coalitions. It focuses on Hispanic health status and needs, and the value of ongoing coalitions of Hispanic-focused organizations as vehicles for information-sharing, cooperation, and advocacy. It identifies issues to consider in developing and maintaining an effective coalition, as well as pitfalls to avoid.

The structure, membership, scope, focus, and operational procedures for a coalition must be designed to meet unique local needs. This document does not provide a blueprint or replicable model for establishing a coalition; however, it should help local groups identify some of those needs and consider appropriate issues and questions in designing and starting a local health coalition. It concentrates on coalitions which include and focus on — but are not necessarily limited to — organizational members, and assumes that Hispanic community-based organizations will assume a lead role in establishing the coalition.

BACKGROUND ON HISPANIC HEALTH STATUS AND NEEDS

Hispanic Americans are on the threshold of becoming the largest ethnic minority in the United States. Hispanics are the youngest and fastest growing major population group in the U.S. Data from the 1990 Census indicate a mainland Hispanic population of 22.4 million — and the Census Bureau's own analysis indicates that this is an undercount of between one and 1.8 million. The Hispanic population has grown by more than 50% in the last decade, with about half the growth attributed to immigration and half to natural increase. With a median age of less than 26 years, about seven years younger than the general population, Hispanics have a high proportion of women of childbearing age. Hispanics also have slightly larger families than non-Hispanics; as of 1991, mean family size was 3.80 persons for Hispanic families and 3.13 persons for non-Hispanics.[1]

Demographic statistics make it clear that Hispanics will soon be the nation's largest minority. They are also likely to continue to be among the least healthy Americans, for various reasons including high rates of poverty, lack of health insurance, and lack of adequate health information. Hispanics are three times as likely to be poor as Whites, with a 1990 family poverty rate of 25.0% compared to 8.1% for Whites,[2] as found in the March 1991 Current Population Survey. The Puerto Rican family poverty rate is 37.5%, higher than the Black rate of 29.3% and the Mexican American rate of 25.0%.[3] While Hispanic males have the highest labor force participation rate of any major population as of 1990, Hispanics had lower per capita incomes ($8,424) than Blacks ($9,821) or Whites ($15,265); the median family income of Hispanics ($23,431) was slightly higher than that of Blacks ($21,423) but less than two-thirds that of Whites ($36,915).[4] Hispanic males are especially likely to be among the working poor. Hispanics employed year-round, full-time have lower weekly wages than Whites or Blacks, with Hispanic women at the bottom of the wage scale.

The 1986 National Access Survey found that between 1982 and 1986, the percentage of Hispanics reporting themselves to be in fair or poor health increased; this was not true for Whites or Blacks. Moreover, Hispanics were almost twice as likely as non-Hispanic Whites to indicate that they did not have a regular source of health care. Studies have consistently found that Hispanics receive less preventive care than non-Hispanics, and are especially likely to receive prenatal care late or not at all; Hispanics are about three times as likely as non-Hispanic Whites to receive no prenatal care.

National death rate data are not available for Hispanics, but partial data from the National Center for Health Statistics (from 18 states and the District of Columbia) on the leading causes of death show both similarities and major differences among leading causes of death for Hispanics and non-Hispanic Whites. Heart disease and cancer were the first and second leading causes of death for both Hispanics and non-Hispanics in 1987; heart disease accounted for 25% of Hispanic and 37% of White non-Hispanic deaths; cancer accounted for 17% of Hispanic and 23% of White non-Hispanic deaths. Stroke was the fourth leading cause of death for Hispanics, accounting for 6% of deaths, and the third leading cause for White non-Hispanics, accounting for 7% of deaths.

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[1] *The Hispanic Population in the United States: March 1991*, U.S. Bureau of the Census, Current Population Reports, Series P-20, No. 455, Washington, D.C., U.S. Government Printing Office, 1991.

[2] *Poverty in the United States: 1990*, U.S. Bureau of the Census, Current Population Reports, Series P-60, No. 175, Washington, D.C., U.S. Government Printing Office, 1991.

[3] *The Hispanic Population in the United States: March 1991, op. cit.*

[4] *Money Income of Households, Families, and Persons in the United States: 1990*, U.S. Bureau of the Census, Current Population Reports, Series P-60, No. 174, Washington, D.C., U.S. Government Printing Office, 1991.

Unintentional injuries were the third leading cause of death for Hispanics (the first leading cause for Hispanics 38 years old or younger), accounting for 9% of Hispanic deaths, while homicides were fifth and accounted for 5% of deaths. In comparison, injuries ranked fifth for White non-Hispanics and accounted for 4% of deaths; homicides were not among the top 10 and accounted for less than 1% of White non-Hispanic deaths. Liver disease was the sixth leading cause of death for Hispanics, accounting for 3% of deaths, and the 10th for White non-Hispanics, accounting for 1% of deaths.

While health status data remain incomplete, data from the Hispanic Health and Nutrition Examination Survey (HHANES) conducted from 1982-84 indicate that Mexican Americans and Puerto Ricans have two to three times the rate of type II diabetes than that found among non-Hispanics. Hispanics also have twice the percentage of AIDS cases which would be expected given their percentage of the population — three times the percentage of pediatric AIDS cases. Diabetes was the eighth and HIV infection the ninth leading cause of death for Hispanics in 1987. Particular subpopulations of Hispanics, such as migrant and seasonal farmworkers, have especially limited access to health care and are at high risk for accidents and for certain illnesses such as water-borne diseases.

Many factors contribute to Hispanics' lack of access to health care and poor health status. Compounding problems of poverty and low income is a lack of health insurance — and the percentage of Hispanics without health insurance appears to be increasing. According to information from the 1989 Current Population Survey (CPS), 32% of Hispanics — compared to 10% of non-Hispanic Whites, 20% of non-Hispanic Blacks, and 18% of all other groups — lack health insurance. Mexican Americans — who make up about 63% of the Hispanic population — are most likely to be uninsured; 35% of Mexican Americans, 29% of Cuban Americans, and 22% of Puerto Ricans have no health insurance. Mexican Americans and Puerto Ricans are even less likely than Black non-Hispanics to have private health insurance, and less than half of each group has private health coverage. While one-third of Puerto Ricans and nearly one-fourth of Black non-Hispanics are covered through Medicaid, only about one-eighth of Mexican Americans have Medicaid coverage. This appears to reflect the differences in Medicaid coverage by state and region, as well as differences in labor force participation rates. Eligibility for Medicaid requires families to be receiving welfare benefits. Uninsured rates reported from the 1989 CPS are considerably higher than 1982 Harris survey data showing that 16% of Hispanics, 11% of Blacks, and 7% of Whites were uninsured — and in that study, Hispanic reported that they had less insurance coverage in 1982 than in prior years.[5]

Hispanics are severely underrepresented in most of the health professions, and limited-English proficiency can be a significant barrier to obtaining services. While Hispanic-focused community and migrant health centers do exist, their number is small, and many clinics serving Hispanic communities receive little or no federal funding. For many Hispanics, the primary source of health care is hospital emergency rooms.

Lack of preventive care is closely related to but not entirely a result of financial resources. Even Hispanics who have some health insurance often have no coverage for preventive care. Lack of immunization is a serious problem in many communities. Moreover, the concept of "prevention" implies a certain sense of control over the future

[5] Treviño, Moyer, Valdez, and Stroup-Benham, "Health Insurance Coverage and Utilization of Health Services by Mexican Americans, Mainland Puerto Ricans, and Cuban Americans," *JAMA*, Volume 265:2:223-237, January 9,1991.

which many low-income Hispanics lack, and preventive care may not be an immediate priority for individuals worrying about how to meet the basic survival needs of their families. Hispanics are also less likely than non-Hispanics to be reached by health education, promotion, and disease prevention messages. Health promotion messages on topics such as smoking and health or the importance of hypertension screening often do not effectively reach the Hispanic community — and many Hispanic-focused health care providers lack funding for health educators or outreach workers. Most other Hispanic community-based organizations have traditionally seen themselves as family-oriented, but have not viewed health education or prevention efforts as among their priorities.

GROWING HEALTH INVOLVEMENT BY HISPANIC COMMUNITY-BASED ORGANIZATIONS

While most Hispanic community-based organizations do not provide health care, they are committed to assuring that individuals who need such care receive it; therefore, they are becoming more involved in information and referral services. Community-based organizations, by nature of their mission to serve the community, evolve into multi-service agencies; health care becomes another important area under their ever-increasing umbrella of comprehensive services. Finding health care for low-income Hispanics has become a growing challenge due to the increasing cost of health care, decreasing insurance coverage for many working Hispanics, reductions in public funding, and the decreasing availability of indigent care in many hospitals and emergency rooms. Similarly, while the health status data available to Hispanic community-based organizations are extremely limited, the existing information makes it clear that many health problems are preventable — and the importance of health education and prevention has become increasingly evident. Hispanic-oriented community health centers and migrant clinics also recognize the critical importance of health education and promotion and disease prevention activities.

Perhaps the only silver lining to be seen in the very dark HIV/AIDS cloud is the awareness it has created among family-oriented Hispanic community-based organizations that comprehensive health education and prevention are indeed important functions which should be integrated into their ongoing activities. For example:

- Groups involved in HIV prevention are finding that the most appropriate means of presenting such information to Hispanics is as part of broader health education and prevention efforts, with strong linkages to sexually-transmitted diseases (STDs).

- Organizations are finding that incorporating HIV, STD, substance abuse, and other health prevention messages into their education curriculum can be a valuable part of ongoing education or youth components.

- Groups involved in HIV and/or substance abuse prevention have found that many other Hispanic-focused organizations in the community are happy to have education or prevention programs introduced as part of their own ongoing work with existing groups, such as Head Start parents, job training clients, youth enrichment program participants, or adult literacy or English-as-a-Second-Language (ESL) classes.

- Because information sharing, cooperative action, and advocacy are such an important part of HIV/AIDS prevention and education, many organizations have founded or joined Hispanic-oriented AIDS coalitions. The next logical step for many is involvement in a broader health coalition.

BARRIERS TO HISPANIC ORGANIZATIONS' INVOLVEMENT IN HEALTH-RELATED ACTIVITIES

Despite the growing commitment to health-related activities among family-focused Hispanic community-based organizations, many of these groups do not have access to the funding, materials, curriculum, training, or other resources needed for health education or prevention activities. They may have few linkages to mainstream health service providers. As a result, they are missing critical opportunities to include chronic disease, tobacco and substance abuse, and STD education and prevention in their existing programs. Several barriers discourage Hispanic organizations' involvement in health education and promotion. For example:

- **Comprehensive and comprehensible information on Hispanic health status readily available to community-based groups.** Most minority-oriented materials provide very limited Hispanic-specific data. While valuable analyses have recently been published in various medical and health professions journals, this information is not in a form or style which is easily used by community-based organizations, either to educate themselves and their communities, or to use as a basis for resource and program development.

- **Available materials are often culturally inappropriate for Hispanics.** The vast majority of minority-oriented preventive health efforts do not specifically target Hispanics, and Hispanic groups interested in initiating such efforts find that they cannot use available materials and approaches due to problems of language, focus, or presentation. For example, sexually explicit warnings about teenage pregnancy, STDs, and HIV/AIDS may be considered insulting — or may not be understood. Written materials may be too complex, inappropriate in focus or content, or unavailable in Spanish.

- **Organizations which are not health care providers often have no idea where to obtain information, materials, or funding for preventive health efforts.** They typically lack contacts with public agencies at the local, state, or national level which are involved in health education, prevention, and promotion.

- **Too often, Hispanic community-based organizations are not included in health education, prevention, and promotion initiatives.** They are not contacted by public or mainstream nonprofit organizations about health promotion efforts or asked to be part of coalitions. Sometimes, they feel unwelcome when they request information or involvement; more often, there is simply no effective attempt to identify and involve them. Many Hispanic groups do not take the first step themselves, requesting or demanding participation in coalitions or working groups.

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- **Many Hispanic groups which are committed to increasing involvement in health education, prevention, and promotion activities lack the contacts or information to get involved** — they need consultation on how to join or establish health coalitions, work with mainstream providers to assure that large-scale outreach and preventive health efforts effectively target Hispanics, and obtain materials and initiate their own preventive health activities.

If Hispanic health status is to improve, there must be significant improvements not only in access to health care, but also in community awareness about health issues. A major requirement is increased health promotion and outreach targeting Hispanics — using materials and approaches that are culturally appropriate for the local Hispanic population. Existing health coalitions that include limited or no Hispanic involvement cannot reach Hispanics for health promotion efforts or improve Hispanic access to health care. On the other hand, even with the limited materials available, health coalitions with strong Hispanic participation can play a critical role in assuring that community outreach, education, and health promotion occur.

IMPORTANCE OF COALITIONS

Coalitions — groups of independent organizations which join together for information sharing, advocacy, or other cooperative activities ranging from research to service delivery — are an increasingly important vehicle for accomplishing positive community changes benefitting Hispanics. Yet few Hispanic communities have systematically analyzed the potential value of coalition action, and coalitions are more often *ad hoc* responses to crisis events than rationally planned structures designed to meet specific, defined community needs. Few large-scale coalitions have been organized, formed, and led by Hispanic community-based organizations.

Most Hispanic nonprofit human service or community development organizations are members of at least one — and often many — coalitions. Often, groups of organizations form short-term, *ad hoc* coalitions to respond to a particular event. Coalitions are sometimes formed to coordinate fund-raising or other special aid efforts; for example, Hispanic organizations in several cities formed coalitions to help with Mexican or Salvadoran earthquake relief efforts. Coalitions may also respond to local events; for example, a racist statement by a public official or a biased TV news report may lead to a coalition of civil rights organizations demanding an apology, a firing or resignation, and appropriate changes in behavior. Proposed legislation and budget actions often generate coalition action; health centers may join together to seek new state funding for indigent health care, to support a local initiative to make health care available to all residents regardless of immigration status, or to oppose proposed state or local budget cuts or action to close a hospital emergency room to those who cannot pay.

Some coalitions are formed with the expectation that they will continue to exist over a long period, often to address a particular program or policy issue of ongoing concern. Thus there are HIV/AIDS, education, employment, immigration, and human rights coalitions in many communities which are particularly active during policy debates and budget battles, but are ongoing entities. Some communities have coalitions of Hispanic or minority agencies funded by United Way. Others have coalitions whose common interest is that they all provide services to a particular population or in a particular neighborhood. In some communities, coalitions of Hispanic-controlled or Hispanic-focused organizations have been formed. Many ongoing coalitions were initially established to address a crisis need but proved so valuable that their scope and activities were continued long-term or expanded to meet other needs. Thus short-term efforts can be transformed into long-term coalitions. Health coalitions formed around a particular crisis such as HIV/AIDS or substance abuse may continue with a broader health focus.

Coalitions need not be composed only of organizations. Many coalitions also include individuals who are considered representative of identified population segments (such as the business community, health professionals, teachers, or ethnic subpopulations). Some coalitions also allow individual members to join because of their personal interests. The critical issue in dealing with individual members in a coalition of organizations is how to give individuals a meaningful role while maintaining a decision-making process which recognizes that the organizations represent a constituency of many individuals.

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WHY FORM A COALITION?

Coalitions are typically formed to meet one or more of the following needs:

- **To accomplish a specific advocacy goal,** where individual advocacy agency efforts are likely to be less effective than a unified community voice in support of or opposition to a particular policy, program, or action — for example, to urge the city or state to take a more active role in providing access to health care for migrant or newly arrived immigrant populations or to fully implement the Ryan White CARE bill.

- **To reduce staff and other costs for accomplishing a common goal by sharing work and responsibilities** — for example, to run an immunization campaign covering several neighborhoods.

- **To share information or ideas** so that all coalition members are better informed about important issues or programs — such as new laws or regulations affecting the availability of health care.

- **To decrease isolation and increase collaboration,** enabling organizations which cannot easily carry out specific activities individually to participate indirectly through the coalition's activities — for example, to enable a small organization to lend its support to health outreach.

Ongoing coalitions are typically established or maintained where the participating agencies believe that the coalition can be an effective long-term vehicle for accomplishing information sharing, advocacy, or other mutual goals. Sometimes, coalitions may actually deliver services — for example, carry out a joint immunization or diabetes education campaign, research and policy analysis, or do a needs assessment survey of critical health needs in the Hispanic community. This may require staff and a budget. Often, coalitions exist without staff, and with no budget except modest dues or contributions from members.

The effectiveness of a coalition depends to a considerable degree upon the organizational skills, commitment, interest, and contributions of time and effort of its members. Even with staff, coalitions are rarely effective unless they are bound by commitment, shared interests, and priorities sufficient to insure ongoing participation by a significant proportion of their members. A coalition is likely to survive if it proves effective enough that there is a high positive return on the time and other resource investments of its members. Thus a coalition which successfully supports or opposes legislation or regulations, gets a city to change an unfair policy, or accomplishes other agreed-upon objectives is likely to survive and grow.

CHARACTERISTICS OF EFFECTIVE COALITIONS

One important question is what makes a coalition effective. There is certainly no single structure, focus, or approach which will be effective in all communities. However, certain common factors describe most effective coalitions which are established primarily for information sharing and advocacy. These apply to most health coalitions, and include the following:

1. **It has a clearly defined purpose and scope.** Goals, objectives, and strategies are made clear and understandable. The coalition does not try to do everything; instead, it has a clear focus. Usually this will include both information sharing and advocacy related to a specific community or population, or a set of issues or programs. For example, a health coalition might want to focus initially on a particular health promotion topic such as immunization or preventing sexually transmitted diseases, or on a specific community or health problem such as lack of emergency health care for low-income families.

2. **It operates based on agreed-upon, written principles** which specify its focus, scope, and priorities. It does not take action on issues which do not fit its principles, and it evaluates new issues based on its past involvement and effectiveness.

3. **It develops clear membership requirements,** and specifies whether members may include anyone other than organizations; it determines what kinds of entities are eligible for membership and applies these criteria consistently. If a health coalition is to be broad-based, there is a decision about how to maintain a balance between private and public agency members.

4. **It requires that all its members "sign on" to its principles,** and thus assures basic agreement on its purposes and scope. It also has the right to state these principles publicly, and to list the member agencies which have agreed to them.

5. **It has a clear procedure for getting members to "sign on" to specific positions on issues,** and it is possible to be a member of the coalition without supporting each of its specific actions. Thus if the coalition sends a letter supporting or opposing a particular set of proposed programmatic and funding guidelines governing a new health promotion program, the names signed to that letter will be those members who specifically support that action.

6. **It has regular meetings, but does not meet without a substantive agenda that needs attention.** During quiet periods, it meets less often than during periods of major program activity or policy debate. Meetings are either held in a central location acceptable to all members, or rotated among several locations so that travel time and responsibilities are equalized.

7. **If the coalition is large — more than 10 or 12 members — there is some form of steering or executive committee which meets more often than the whole coalition.** This committee must have formal sanction, such as being elected by the membership. It must be "representative" based on the composition of the total coalition. It usually does not set policy for the coalition, but it does review issues and make recommendations for action by coalition members.

8. **It maintains and uses its leadership to enforce an environment of cooperation,** and does not permit individual members to use the coalition for their own purposes. One of the greatest challenges in building and maintaining an effective coalition is the need to make all organizational members feel that they have a real voice, and that the coalition is not dominated by a few individuals or organizations which use the entity not to meet agreed-upon joint objectives, but to support their own interests or give themselves visibility. A leadership group which demonstrates its commitment to full participation and takes immediate action to prevent domination by self-serving members is critically important.

9. **It does not take positions which are bound to be divisive** because they pit the interests of some coalition members against the interests of other members. For example, a coalition which supports increased access to health care for poor people can avoid damaging infighting by having a policy that it will NEVER support funding for one program which benefits poor people over another program which also benefits poor people. Thus the coalition may support domestic over defense spending, means-tested programs over non-means-tested programs, or new taxes rather than budget cuts; but it will not urge cuts in health facilities construction programs as a means of obtaining more funds for health education programs. A coalition of organizations serving a particular neighborhood will fight to have additional funds allocated to that neighborhood, but will NOT urge that monies be spent on one program rather than another.

10. **It is effective in obtaining resource commitments from its members,** and allows those with limited financial resources to make in-kind contributions. Many effective coalitions have minimal membership dues or have sliding membership scales, so that larger organizations with greater means pay more. Effective coalitions also recognize that some organizations, regardless of size, may not be able to provide membership dues but may be able to do photocopying, provide postage or do mailouts, type materials, or otherwise provide staff or other services of equal value.

11. **It is effective in obtaining time commitments and ongoing active participation from its members.** At one level, this occurs when the coalition is effective and members realize that they would be unlikely to obtain the same results working independently. At another level, member participation also depends upon a Chairperson and other key coalition members who encourage and reward participation. For example, the coalition should provide visibility, public thanks, and leadership positions to individuals who contribute time for outreach or advocacy, write briefing papers or press releases, or otherwise further the coalition's agenda. Most effective coalitions have several task forces or committees which meet regularly and address major issues; they may be organized based on issues (e.g., HIV/STD, immunization, diabetes) or types of action (e.g., outreach, research, advocacy, public relations).

12. **It finds ways to obtain staff resources.** This may mean a small grant from a public source, foundation, or church group, or pooling of membership dues to obtain staff or consultant help. Staffing can also be arranged on a volunteer basis, by using a retired nonprofit agency executive, a graduate student who must do a community internship as part of a master's program, or a staff person who can be spared by an agency for a specified period of time. Usually, a coalition which is very active and effective eventually decides that it needs some kind of formal budget and staffing, often working out of a member agency's facilities. However, this does not usually occur until the coalition has proven its effectiveness as a volunteer entity, and its members are committed to its continued existence.

ESTABLISHING A HEALTH COALITION

A health coalition of Hispanic community-based organizations — or one involving Hispanic and other organizations committed to improving health status in a particular community or larger geographic area — can be extremely valuable in increasing cooperation, making all members better informed, developing a strong advocacy voice, and accomplishing positive changes in the community. It can be extremely useful in responding to opportunities or crises because it will not have to be established on short notice, and will already have a structure and procedures which will allow it to respond quickly and effectively when the need arises. It can enable a community to react quickly and positively to new programs or funding opportunities, especially the growing number of programs calling for documentation of broad community involvement.

Like other coalitions, a health coalition is most likely to be effective and long-lasting when it is developed carefully and with the greatest possible involvement of the key personnel of organizations which are expected to be its members. The following is one reasonable set of steps for establishing an effective health coalition.

1. **Get together a representative leadership group from potential member entities.** If the coalition is likely to involve representatives of various sectors, be sure the group includes people from each sector. Consider the need for involvement of various nationality groups, and — if the coalition will include both Hispanics and non-Hispanics — other minorities, low-income communities, service providers, etc.

2. **Determine why a coalition is needed, and what might be its appropriate purposes, scope, and priorities.** Determine what the coalition will do and what it will not do. Be as specific as possible.

3. **Develop a written summary of the coalition's focus,** and be sure all leadership group members find it satisfactory.

4. **Using the members of the leadership group, systematically meet with the leaders of all entities you want to join the coalition.** Use the written summary as a basis for discussion, and determine their interest in participating. Identify any problems they have with the proposed purposes, scope, and priorities of the coalition to bring back to the leadership group.

5. **If there seems to be reasonable support, hold an organizing meeting.** Try to get agreement on the scope statement, address other areas of concern, and if there is broad agreement that the coalition is needed, agree on a schedule and specify responsibilities for getting it started.

6. **Draft a statement of principles and have entities sign on,** with the understanding that this is the minimum requirement of membership.

7. **Select a steering or other leadership group** which is representative of the range of interests and types of groups in the full membership, willing to commit time and energy to coalition development, and acceptable to the full membership.

8. **Using this group as leaders, establish a series of *ad hoc* committees to plan for various aspects of the coalition's activities,** such as issue or health-needs priorities and specific agendas, procedures for "signing on" to various letters or other materials, mailing list development, membership dues or in-kind needs, etc. Involve all members in one or more committees, charge them with drafting brief policy reports, and arrange a full coalition meeting to discuss and make decisions on committee reports.

9. **Have a one-day retreat or major meeting to adopt procedures and establish priorities for at least the first six months of activities.** Be sure that task forces or committees are assigned to see that each major task is carried out. Be sure that at least one or two "winnable" issues or activities with a high probability of positive impact are included, so that the coalition can experience some early success. Take on a short-term project such as a defined outreach campaign on a particular health problem. Recognize that some crises requiring action are also likely to occur.

10. **Use the steering group actively during the initial period** to encourage positive results and recommend changes in procedures or other appropriate action to resolve any early problems. Be sure someone is responsible for encouraging all members to be active in major coalition activities. Do outreach to add new members if some important groups do not initially join. Be sure that the coalition carries out some visible activities, and that mailings keep all members informed. Hold special coalition meetings whenever issues require this, and have at least quarterly meetings otherwise; the steering group should meet at least monthly during the early period.

11. **Assess progress at the end of six months,** have another major coalition meeting if needed, and make changes. Remember that coalitions take time to become strong, and that cooperation and trust among agencies must develop based on positive experience.

PITFALLS TO AVOID

Building and maintaining successful coalitions requires considerable time and effort — and the ability to avoid certain pitfalls that may weaken or destroy the organization. For example:

1. **Losing the focus or goal of the coalition.** If a coalition moves from one topic to another, or becomes more broadly based by adding more issues than originally planned, the original goal or focus of the coalition may become lost in the process. This may lead organizations to leave the coalition due to lack of results or cause strife among organizations that feel confused and unfocused. Coalitions should have clear procedures for reviewing and approving new issues or focus areas.

2. **Losing sight of your own organization's goals.** A community-based organization can become too involved in the needs and functioning of a coalition. When the goals of a member organization are becoming co-opted or changed due to involvement in a coalition, the individual organization must reassess its participation in the group. This problem can often be avoided by assuring that your organization's positions and priorities are well defined before it joins a coalition.

3. **Over-commitment of resources.** An organization may become involved in a coalition effort in order to reduce the resources committed to a specific issue, only to find that the coalition requires more resources — personnel time, in-kind support, or fiscal support — than originally planned. A member organization may find that its staff representative is neglecting ongoing duties due to coalition work. This requires a judgment call: if a short term allocation of extra resources will achieve a critical goal of the coalition, the commitment may be justified; if not, the organization may need to cut back or even withdraw from the coalition effort.

4. **Difficulty in achieving consensus, compromise, or agreement on an issue.** Issues tend to become complicated over time with various groups maneuvering or supporting issues for their own interest. It is important to create an atmosphere in which all members understand the process for reaching a decision and how to bring closure to discussions. Roll-call votes are appropriate for substantive discussions such as whether the coalition will put its energies into supporting an issue. However, NEVER allow issues of ethics or personal morals to be controlled by majority vote. If a member feels personally or morally compromised, the damage may be irrevocable and the coalition will be weakened.

5. **Unpopular stands by the coalition.** A coalition may at times find it necessary to take a very difficult position that may negatively affect a member organization. This possibility should be considered before joining the coalition. If controversial issues being addressed are not part of an organization's scope of activities or are addressed in a fashion not in the organization's style, then it may be wise not to join. Also, before taking on an issue which may become politically troublesome, the coalition should make sure that there is strong member support and commitment over the long term. This careful planning on the part of the individual organizations and the coalition can help minimize the likelihood that certain issues will become divisive, and that coalition members will fall prey to political pressure and choose not to be associated with the cause. It will avoid creating a sense that the coalition is weakening, which opponents can use against your efforts.

6. **Having one individual or group become viewed as synonymous with the entire coalition.** If one organization or individual acts as the spokesperson or if all correspondence emanates from the same office, this one player may be seen as the lead or dominant voice. This weakens the coalition's status as a broad-based entity, and may cause other members to reduce or withdraw support. This problem can be avoided by dividing up the efforts of the coalition: send faxes from one office, send correspondence from another, consider creating a rotating Chair for the official spokesperson position.

7. **Internal politics.** As member groups work to form collaborative agreements, historical competitors may create a negative atmosphere and the coalition may suffer. If competition and conflict do occur among several groups, the leadership of the coalition must take immediate steps to address the problem, not only by reaching agreement on the issue, but also by requiring an open decision-making process and mutual respect and cooperation. Private discussions with leaders of the groups in conflict may be required to reach agreement as to behavior within the coalition. To minimize this problem, be sure before soliciting members that you understand the political situation. Unless the coalition can create a sense of agreement, it cannot be effective.

8. **Possessiveness or "ownership" of coalition ideas or actions.** If a group enters a new field or is extremely successful in its efforts, questions of "owning" the issue or success may arise. The coalition should be quick to give credit to individual members for their ideas and assistance, while retaining for the full coalition the recognition for the success. Similarly, members should understand that the coalition exists to improve life in the community, and results are far more important than who receives credit for the work.

9. **Poor communication among members.** Communication to members can be a great challenge, especially when coalitions operate without staff. Yet the cohesiveness and unified voice of a coalition will quickly disappear unless all members are kept informed of activities and progress and have the opportunity to participate in decisions. It is extremely important for a coalition to make provisions assuring that all members have adequate notice of meetings, know in advance about policy decisions to be made, and receive timely updates about the progress of advocacy or other activities.

10. **Failure to agree upon who will serve as spokespersons.** During particularly hectic periods, collaborative efforts tend to take on the character of the many-headed hydra monster, with each mouth issuing a different message. Before such confusion occurs, map out clear levels of responsibility for communication to outsiders, including policy makers and the media. Often, the coalition Chairperson will share this responsibility with committee or task force Chairpersons expert in a particular issue area. If a breakdown or confusion does occur, it is extremely important to call the group together and try to resolve it immediately.

CONCLUSION

Whatever the specific steps used to establish it, a health coalition has the greatest chance for success if it has a manageable scope of activity, effectively involves all its members, and focuses on activities which would be difficult for member organizations to address successfully on their own. Keep in mind other collaborative efforts which may exist in your community; assess whether it would be more advantageous to join those efforts or to create your own collaborative organization. Health coalitions cannot solve all the community's problems. However, if a health coalition is well-thought out and structured with long-term effectiveness in mind, it can achieve goals beyond the limitations of its individual members. An effective coalition is truly more than the sum of its parts.

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